Supreme Court U.S.
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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

ELLEN AUDET AS NATURAL MOTHER, GUARDIAN AND NEXT BEST FRIEND OF ASHLEY AUDET, A MINOR,

Petitioner,

vs.

PRUDENTIAL HEALTH CARE PLAN, INC.,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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48 pp

QUESTION PRESENTED

Are punitive damages available under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461, when an ERISA-governed health maintenance organization (HMO) alters a medical report recommending treatment and, under egregious, unjustifiable and possibly fraudulent circumstances, uses it to deny life-sustaining medical care for a child?

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PETITION FOR WRIT OF CERTIORARI

Petitioner, Ellen Audet as natural mother, guardian and next best friend of Ashley Audet, a minor, respectfully requests that a writ of certiorari be issued to review the judgment of the United States Court of Appeal for the Eleventh Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit is not reported but is included in the appendix in its entirety. The opinion of the United States District Court, Southern District of Florida is not reported but also is included in the appendix in its entirety.

BASIS FOR JURISDICTION

The judgment of the United States Court of Appeals for the Eleventh Circuit was entered on November 27, 1998. Jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1) and Sup. Ct. R. 10(a). The United States Court of Appeals for the Eleventh Circuit has decided an important federal question in a way that conflicts with an opinion of a state court of last resort: *Weems v. Jefferson-Pilot Life Insurance Company, Inc.*, 663 So.2d 905 (Ala. 1995), *cert. denied*, 516 U.S. 971, 116 S.Ct. 434, 133 L.Ed.2d 348 (1995).

There was no petition for rehearing. However, when Ellen Audet filled her initial brief in the United States Court of Appeal for the Eleventh Circuit she also filed a Suggestion of Hearing *En Banc* pursuant to the rules of that court. That

request was denied on October 26, 1998, before that court issued its opinion on the merits.

THE FEDERAL STATUTE INVOLVED IN THIS CASE

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1132(a) provides in relevant part:

> A civil action may be brought--
> (1) by a participant or beneficiary--
> (A) for the relief provided for in subsection (c) of this section, or
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
> . . . .
> (3) by a participant, or beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

STATEMENT OF THE CASE

A. The Proceedings Below:

Ellen Audet brought this claim on behalf of her twelve year old daughter, Ashley Audet, in state court in Florida on May 1, 1996. Prudential removed the law suit to the United States District Court, Southern District of Florida as this

matter is governed by Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461. On March 14, 1997, Ellen Audet sought leave of court to plead punitive damages. That motion was denied. Later, Ellen Audet again asked the District Court for leave to assert similar punitive relief based upon discovery of evidence that Prudential, through its agents, had altered medical records of Ashley in order to create a record upon which they could justify a denial of ERISA benefits and life-sustaining health care. That request to amend was also denied. The matter was tried non-jury and judgment was entered in favor of Audet on December 23, 1997 for the full amount of Ashley's medical bills. The district court found that Prudential's "denial of benefits was an abuse of the administrator's discretion" and that "under all of the facts considered in this case, it was arbitrary and capricious to deny the professional chest physiotherapy benefits to the insured." On January 22, 1998, Plaintiff filed a Notice of Appeal specifically addressed to the denial of leave of court to plead punitive damages and to allow a jury trial. On November 27, 1998, the United States Court of Appeals for the Eleventh Circuit affirmed the District Court's orders and judgment.

B. Statement of the Facts:

The District Court made the following findings of fact relevant to this petition which are taken almost verbatim from the Findings of Fact and Conclusions of Law issued by the District Court:

1. Chest Physiotherapy and the ERISA HMO Plan:

Ashley Audet, a minor suffering from cystic fibrosis, was insured through her mother's Health Maintenance Organization (HMO) employment plan, The Prudential Health Care Plan, Inc. The insurance policy in question was part of an employee welfare benefit plan covered under ERISA. There was also no dispute that chest physiotherapy was administered to Ashley Audet to loosen the secretions that her cystic fibrosis causes to accumulate in her lungs. Likewise, there was no dispute as to the qualifications of the chest physiotherapist or as to the reasonableness of the amount of the bills for the treatment between May 29 and September 1, 1995. The plan had denied the benefits to the insured under the exclusion for "custodial care" that may be provided by a non-professional. In other words, according to Prudential, Ashley Audet's cystic fibrosis was not sufficiently aggravated to require a professional therapist and the type of chest physiotherapy that needed to be performed could be done by a lay individual with minimal training. Therefore, Prudential declined to award the benefits.

Although a lay person may supplement that chest physiotherapy and, in fact, Ashley's mother provided such therapy for a long period of time, the District Court found that Ashley's health condition required the services of professional chest physiotherapists. The District Court also found that in order to provide the type of chest physiotherapy that was necessary to expel the secretions from the lungs, sufficient training was necessary. The District Court found that Ashley Audet's claims for chest physiotherapy treatment by a licensed professional respiratory therapist were

reasonable and medically required because of her cystic fibrosis.

2. The HMO's Review of the Request for Treatment:

Prudential, through Nancy Murphy, testified that no case manager had been assigned to Ashley Audet's case and it was obvious that an insufficient number of case managers existed (only one!) to handle the 100,000 subscribers. More importantly, Ms. Murphy's recommendation to Prudential's medical director, Dr. Melvyn Fletcher, that the benefits should be denied was made without Ms. Murphy possessing sufficient knowledge regarding chest physiotherapy or the severity of Ashley Audet's cystic fibrosis. Ms. Murphy's opinion clearly contradicted the prescription by Dr. Birriel, the patient's own physician.

3. Alteration of Medical Records:

Although the District Court refrained to take evidence specific to punitive damages, sufficient facts already exist in the record to infer that punitive damages would be justified in this case. The issues raised in this petition are purely legal in nature. If this Court were to allow a claim for punitive damages, Audet acknowledges that the facts for such a claim must be fully developed at the trial level. Nonetheless, Audet provides the Court with the following facts already in the record to show that the question presented is more than an academic inquiry:

Before denying care to Ashley Audet, Prudential sent a respiratory therapist to Ashley's home to examine her and

render an opinion on the need for therapy. That licensed therapist, Karen Heins, was employed by Home Care Medical, Inc., a company with which Prudential contracted for various services. Heins examined Ashley and wrote a report stating that the therapy for Ashley was necessary and that it was needed five times per week by a professional therapist. The full text of the original report of Karen Heins was attached by the District Court as an exhibit to the Court's Findings of Fact and Conclusions of Law." (See Appendix).

It can be fairly inferred that Prudential participated in altering medical records to justify denying care for Ashley. After receiving Karen Heins' report, Prudential's nurse, Nancy Murphy, called Heins' superior, Tony Cataldi, Jr. After that telephone call, the altered report appeared in Ashley's medical records at Prudential. The therapist who visited Ashely and authored the original report, Karen Heins, testified that she did not make the changes and that she was unaware of the changes to her report until shortly before she was deposed in this case. Tony Cataldi, Jr., who is the owner of Home Care Medical, admitted that after his telephone call with Nancy Murphy, he altered the document without telling Heins or having any further evaluation of Ashley. It can be fairly inferred from the results of the Murphy-Cataldi telephone call that Murphy, acting as an agent of Prudential, requested that Cataldi alter Heins' evaluation of Ashley Audet or at least participated in the alteration enough so that Prudential could have a record to justify denying Ashley therapy. The full text of the altered report was also attached by the District Court as an Exhibit to the Court's Findings of Fact and Conclusions of Law." (See Appendix). The altered report went to Prudential's medical director who used it to

deny therapy for Ashley. Heins' original report did not go to the medical director.

REASONS FOR GRANTING THE WRIT

I. The Conflict:

The decision of the United States Court of Appeals for the Eleventh Circuit in this matter directly conflicts with a decision of the Supreme Court of Alabama. *Weems v. Jefferson-Pilot Life Insurance Company, Inc.*, 663 So.2d 905, 912 (Ala. 1995), *cert. denied*, 516 U.S. 971, 116 S.Ct. 434, 133 L.Ed.2d 348 (1995). It also conflicts directly with the plain language of this Court's opinion in *Ingersoll-Rand Company v. McClendon*, 498 U.S. 133, 111 S.Ct. 487, 112 L.Ed.2d 474 (1990). The *Weems* decision was based almost entirely upon this Court's opinion in *Ingersoll-Rand*. The Supreme Court of Alabama stated: "The Supreme Court, in *Ingersoll-Rand*, has now specifically held that the courts are authorized to award damages, both extra contractual, and even punitive, where the facts support them, though they are not specifically provided for in ERISA." *Weems v. Jefferson-Pilot Life Insurance Company, Inc.*, 663 So.2d 905, 912 (Ala. 1995) (citing: *Haywood v. Russell Corp.*, 584 So.2d 1291 (Ala. 1991)). That conclusion of the Alabama court was drawn from Justice O'Connor's majority opinion in which she wrote: "It is clear that the relief requested here is well within the power of the federal courts to provide." *Ingersoll-Rand Company v. McClendon*, 498 U.S. at 145. The relief requested by Mr. McClendon in that case included: "lost future wages, mental anguish and **punitive damages** as a result of [a] wrongful discharge." *Ingersoll-Rand v. McClendon*, 498 U.S. at 136 (emphasis added).

Commenting on these points of Justice O'Connor's opinion, the *Weems* court wrote: "This court can read and understand the English language and believes that the Supreme Court would not say something this important without being careful and deliberate in its choice of words." *Weems*, 663 So.2d 905, 911. In *Weems*, the plaintiff sued Jefferson-Pilot Life Insurance Company for failing to pay hospital charges associated with treating his heart attack after Jefferson-Pilot had certified or otherwise approved the hospitalization. After losing the case in the Supreme Court of Alabama, the ERISA-governed insurer filed a petition for a writ of certiorari with this Court but this Court denied that request. *Jefferson Pilot Life Insurance Company, Inc. v. Weems*, 516 U.S. 971, 116 S.Ct. 434, 133 L.Ed.2d 347 (1995). The two dissenters in *Weems* have relied upon the denial of certiorari as indicative that punitive damages and a jury trial are allowed under ERISA. *Ex parte Metropolitan Life Insurance Company*, 679 So.2d 686, 689 (Ala. 1996). Likewise, United States District Judge William M. Acker of the Northern District of Alabama believes that *Weems* correctly followed this Court's directive, notwithstanding the decisions of the United States Court of Appeals for the Eleventh Circuit. *Anderson v. Metropolitan Life Insurance Company*, 1997 WL 115863 (N.D. Ala. 1997). The Eleventh Circuit has noted a need for this Court to address the issue by pointing out that: "[T]he United States Supreme Court has not conclusively spoken on the issue of whether ERISA § 502(a)(3) encompasses extra-contractual or punitive damages . . . ." *McRae v. Seafares Welfare Plan*, 920 F.2d 819, 821 (11th Cir. 1991).

The conflict is not confined to the Eleventh Circuit but rather reaches into other United States Courts of Appeals. At

least seven of the Circuit Courts that have spoken on this issue likewise conflict with *Ingersoll-Rand* and the *Weems* holding. *See Turner v. Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 (1st Cir. 1997), *cert. denied*, ___ U.S. ___, 118 S.Ct. 1512 (1998); *Hemelt v. U.S.*, 122 F.3d 204, 207 (4th Cir. 1997); *Zimmerman v. Sloss Equipment, Inc.*, 72 F.3d 822, 828 (10th Cir. 1995); *Landwehr v. DuPree*, 72 F.3d 726, 735 (9th Cir. 1995); *Medina v. Anthem Life Insurance Company*, 983 F.2d 29, 31 (5th Cir. 1993), *cert. denied*, 510 U.S. 816 (1993); *Harsch v. Eisenberg*, 956 F.2d 651, 660 (7th Cir.), *cert. denied*, 506 U.S. 818 (1992); *Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270, 286 (2nd Cir.1992).

II. Conflict With Congressional Intent:

The above opinions of the United States Courts of Appeal denying punitive damages also run counter to declared Congressional intent. In 1988, the Education and Labor Committee of the House of Representatives addressed the complications of ERISA preemption when applied to wrongfully denied health insurance claims:

> In recent years, the Committee has received numerous complaints and inquiries from Members of Congress and their constituents about improper denials of medical claims, improper denials of continuation of coverage, or unreasonable delays in processing claims by employers or insurers.

H.R. Rep. No. 801, 100th Cong., 2d Sess. p.2 at 63 (1988).

The Committee considered the concerns of its constituency and the possibility that this Court's decision in *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) would eliminate, by means of preemption, the traditional protections and deterrents that the states have developed to curb insurance company bad faith:

> Participants in ERISA-covered employee benefit plans that have been treated in this manner are concerned that the Supreme Court's interpretation of ERISA . . . as preempting state laws that authorize punitive or other extra-contractual damages in connection with cliams for benefits effectively denies them legal recourse. The Committee shares their concern.

H.R. Rep. No. 801, 100th Cong., 2d Sess. p.2 at 63 (1988).

The Committee concluded, however, that further legislation was not needed because in their view the legislative history on ERISA was already clear. Congress intended the federal courts to shape legal remedies that included punitive damages:

> The Committee believes that the legislative history of ERISA and subsequent expansions of ERISA support the view that Congress intended for the courts to develop a federal common law with respect to employee benefit plans, including the development of appropriate remedies, even if they are not

> specifically enumerated in Section 502 [29 U.S.C. § 1132] of ERISA. . . . In cases in which, for instance, facts and circumstances show that the processing of legitimate benefit claims has been unreasonably delayed or totally disregarded by an insurer, an employer, a plan administrator, or a plan, **the Committee intends the federal courts to develop a federal common law of remedies, including (but certainly not limited to) the imposition of punitive damages** on the person responsible for the failure to pay claims in a timely manner.

H.R. Rep. No. 801, 100th Cong., 2d Sess. p.2 at 63 (1988) (emphasis added).

The federal courts recognize that Congress has vested them, and ultimately this Court, with the decision making authority to develop ERISA remedies. *Kane v. Aetna Life Insurance*, 893 F.2d 1283, 1285 (11th Cir. 1990).

III. The "Dissenting" District Court Judge:

In 1997, United States District Judge William M. Acker of the Norther District of Alabama stated: "[T]he congressional purpose for enacting ERISA has been subverted by judges' narrow construction of ERISA in a way to make realistic or adequate relief for mistreated plan beneficiaries virtually impossible." *Anderson v. Metropolitan Life Insurance Company*, 1997 WL 115863 (N.D. Ala. 1997). After criticizing the bureaucratic "morass" necessary to contest denial of an ERISA health claim, he wrote: "In the

worse case scenario from the participant's point of view, a fiduciary can deny a claim with absolute impunity." *Anderson v. Metropolitan Life Insurance Company*, 1997 WL 115863 (N.D. Ala. 1997). The District Judge had previously read *Ingersoll-Rand* as allowing punitive damages shortly after this Court issued that opinion. In a *sua sponte* opinion reversing his own ruling on a jury trial issue pending before him, he wrote:

> In *Ingersoll-Rand*, the Supreme Court has now clearly answered the Eleventh Circuit's prayer by giving it the "green light" to fashion ERISA remedies beyond the mere enforcement of claims for unpaid benefits, even though a federally fashioned remedy may bear striking similarity to some pre-emptive state or common law remedy. According to *Ingersoll-Rand*, a court, state or federal, in an ERISA case, may, as an ERISA remedy, award extra-contractual, **even punitive damages**, that is if the facts call for such a remedy. . . . . This court did not and could not express the idea as forcefully as Justice O'Connor has now expressed it.

Blue Cross and Blue Shield of Alabama v. Lewis, 753 F.Supp. 345, 347 (N.D. Ala. 1990)(emphasis added).

After *Weems*, Judge Acker saw some hope that the law would provide some recourse to those who are wrongfully denied medical care by their HMOs and health insurers: "The glimpses of hope for beneficiaries that appear in some of the recent cases to which the Alabama Supreme

Court seems to have subscribed, makes this court want to stay around awhile to see what happens." *Anderson v. Metropolitan Life Insurance Company*, 1997 WL 115863 (N.D. Ala. 1997).

IV. The Historical Disincentive to Insurance Bad Faith--Lacking in ERISA:

Notwithstanding its ruling in Ashley Audet's case, the United States Court of Appeals for the Eleventh Circuit has admitted trepidation in applying the restrictions of ERISA to wrongful denials of employee health insurance claims. The court reversed a decision of District Judge Acker but then ended its opinion in *Amos v. Blue Cross Blue Shield of Alabama*, 868 F.2d 430 (11th Cir. 1989) with this near-apology deferring to this Court to chart the course of law on this issue:

> We acknowledge that by eliminating the possibility that insurance companies may be liable for punitive or extra-contractual damages, **the courts are removing a historical disincentive to insurance company misbehavior**. Consequently, our decision may produce unintended results. However, any change in the law's course will have to be charted by the Congress or the Supreme Court.

Amos v. Blue Cross Blue Shield of Alabama, 868 F.2d 430, 433 (11th Cir. 1989) (emphasis added).

Vis-a-vis the HMO and the insured, there is no risk to deny a claim. The ERISA-governed HMO has "an everything-to-win, nothing-to-lose proposition." *See Chaachou v. American Central Insurance Company*, 241 F.2d 889, 893 (5th Cir. 1957) (in the converse circumstance: insurance fraud by consumer requires greater consequence than mere denial of claim).

By contrast, non-ERISA claimants have a punitive damages remedy as a powerful deterrent to wrongful denial of medical health insurance claims. In Alabama, if an ERISA claimant can prevent removal of his claim to federal court, he also has that deterrent. All other ERISA health insurance claimants have no protective disincentive to deter wrongful denial of their claims. The United States Courts of Appeals have created a hole in traditional consumer protections. They depart from the traditional remedies that control insurance company bad faith. Nearly all of the states in the Union have recognized that punitive damages, in one form or another, are necessary to curb wrongful denial of valid insurance claims.[1]

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[1] Punitive damages are a traditional deterrent to curb insurance company bad faith: *See, e.g., Kapp v. Arbella Mut. Ins. Co.*, 426 Mass. 683, 689 N.E.2d 1347 (Mass. 1998) (punitive damages are proper under M.G.L.A. c. 93A, § 9(3) where evidence warrants finding of wilful or knowing unfair and deceptive practice); *State Farm Mut. Auto. Ins. Co. v. Brown*, 48 Ark.App. 136, 892 S.W.2d 519 (Ark. 1995) (where insurer improperly failed to pay benefits, a 12 percent penalty was properly awarded pursuant to A.C.A. § 23-89-208); *Steward Title Guaranty Co. v. Aiello*, 911 S.W.2d 463 (Tex. 1995) (upheld award of $200,000 in punitive damages against insurer that breached the duty of good faith and fair dealing); *McLaughlin v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 29

(continued...)

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Cal.Rptr.2d 559, 23 Cal.App.4th 1132 (Cal. 1994) (recoverable damages in suit against insurer alleging bad faith cancellation of policy include punitive damages); *Ballow v. PHICO Ins. Co.*, 878 P.2d 672 (Colo. 1994) (punitive damages may be awarded for bad faith breach of insurance contract, if committed with fraud, malice, or willful and wanton conduct); *Serrin v. Northwestern Nat. Life Ins. Co.*, 2 F.3d 373 (11th Cir. 1993) (punitive damages may be awarded where justified by bad faith failure to pay); *Miller v. Nationwide Mut. Ins. Co.*, 112 N.C. App. 295, 435 S.E.2d 537 (N.C. 1993) (punitive damages may be awarded for a bad faith refusal to provide insurance coverage or pay a justifiable claim); *State Farm Mut. Auto. Ins. Co. v. Weiford*, 831 P.2d 1264 (Ala. 1992) (punitive damages may be awarded for bad faith breach of insurance contract if conduct where malice, bad motive, or reckless indifference is shown); *McCullough v. Golden Rule Ins. Co.*, 789 P.2d 855 (Wyo. 1990) (punitive damages for bad-faith denial of insurance claim requires proof of wanton or wilful misconduct by insurer); *Poling v. Wisconsin Physicians Serv.*, 357 N.W.2d 293 (Wisc. 1984) (injured party may recover punitive damages by showing a wanton, willful or reckless disregard for rights of others); *Trimper v. Nationwide Ins. Co.*, 540 F.Supp. 1188 (S.C. Dist. 1982) (plaintiff could recover punitive damages for wilful or reckless failure to settle or investigate his claim where insurer made no effort to investigate plaintiff's claim); *Johnson v. Pilgrim Mutual Ins. Co.*, 425 A.2d 1119 (Penn. 1980) (punitive damages properly awarded against insurer found to have acted with bad motive in refusing to negotiate in good faith); *Dyer v. General American Life Ins. Co.*, 541 S.W.2d 702 (Mo. 1976) (punitive damages may be awarded where supported by proof that insurer acted maliciously, wilfully, intentionally, or recklessly toward the plaintiff); *see also* A.R.S. § 20-461 (1997); Fla. Stat. § 624.155 (1997); A.C.A. § 23-79-208 (1997); Ca. Ins. § 790.03 *et seq.* (1997); Ga. St. 33-4-6 (1997); K.S.A. §§ 40-2404, 40-2407 (1997); LSA-R.S. 22:1220 (1997); M.G.L.A. c. 93A § 9(3) (1997); M.S.A. § 72A.20 *et seq.* (1997); Mo. St. § 375.420, 375.934, 375.942 (1997); Mt. St. 33-18-233 (1997); Neb.Rev.St. § 44-1529 (1997); Nv. St. 686A.310, 686A.183 (1997); Ny. St. § 2601 *et seq.*, Ny. St. § 109 (1997); 36 Okl. St. 36 § 1250.1 *et seq.* (1997); S.C. St. § 38-59-20 *et seq.* (1997); Tn. St. § 56-7-

(continued...)

This lack of any real deterrent has resulted in rampant abuse by HMOs, managed care and other forms of ERISA health insurance and compels attention from this Court.

V. Consumer Outcry; An Important Federal Question:

In 1995, Americans spent $988 billion on health care. That was 13.6 percent of the Gross Domestic Product. U.S. News and World Report (March 9, 1998). The Kaiser Family Foundation and U.S. News and World Report funded a study of Americans' attitudes toward the health care system and their personal experiences. A poll was conducted by the National Opinion Research Center at the University of Chicago from May 31-July 19, 1997. The survey found that two thirds of Americans have had some problem with the health care system and seventy-five percent were worried about facing problems in the future. Seventy percent were concerned that benefits could be reduced and two thirds of those surveyed were concerned that health care could worsen. Brink, U.S. News & World Report (March 9, 1998).

In October, 1996, the ABA Journal cover story chronicled the ill state of HMO health care. *In Pursuit of Health*, ABA Journal, p. 54, (October, 1996). More recently, U.S. News and World Report magazine featured the ill state of HMO insurance and "managed care" in its March 9, 1998 issue. *What is the Value of a Voice?*," U.S. News and World

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105, 56-7-106 (1997); 8 V.S.A. § 4724 *et seq.* (1997).

Report (March 9, 1998); *HMOs were the right RX, Americans got lower medical costs--but also more worries,* U.S. News and World Report (March 9, 1998). That recent issue included a feature on Doctor Linda Peeno, a former HMO medical director, who cited numerous instances of abuse and questionable tactics. The same medical director, a member of the Roman Catholic Loretto Community, testified before Congress on the state of HMO abuse. The full text of her written testimony submitted to the U.S. House of Representatives Committee on Commerce, Subcommittee on Health and Environment is available on the Internet. L. Peeno, *Managed Care Ethics: The Close View,* <http://www.sepp.net/Peenox.html>.

In 1995, a poll of physicians was conducted by the Boston Herald and WCVB-TV in which they found that 61% of physician specialists agreed with the statement that "In HMO plans, business people decide your health care, not doctors." And, 57% of physician specialists agreed that: "HMO plans prevent doctors from providing needed care in order to save costs." *Do Doctors--or Accountants —Control Your Treatment*, Standard Publishing (Nov. 27, 1995), <http://www.tvrundown.com/hmopoll1.html>.

Complaints like these have found their way into one opinion of a United States Court of Appeal. In *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1997), the court recognized and documented with numerous journal articles that managed care is throwing the medical industry into turmoil. Although the sordid state of affairs should be obvious, the more poignant statements of the court are as follows:

> [W]e are far from alone in our belief that market forces are insufficient to cure the deleterious affects of managed care on the health care industry.
>
> Across the country, health care critics and consumers are complaining that the quality of medical treatment in this nation is rapidly declining, leaving "a fear that the goal of managing care has been replaced by the goal of managing costs." Greene, *Has Managed Care Lost Its Soul? Health Maintenance Organizations Focus More on Finances, Less on Care*, Am. Hosp. Publishing, Inc., May 20, 1997. "An increasing number of Americans believe that dollars are more important than people in the evolving [HMO] system. Whether justified or not, this assumption needs to be taken seriously, according to keepers of the industry's conscience. . . . *Id.*"

Herdrich, 154 F.3d at 374-75.

The Seventh Circuit went on to say:

> The specter of money concerns driving the health care system, says a group of Massachusetts physicians and nurses, "threaten[s] to transform healing from a covenant into a business contract. Canons of commerce are displacing dictates of healing, trampling our profession's most sacred values. Market medicine treats patients as profit

> centers. "*For Our Patients, Not for Profits: A Call to Action*, JAMA, Dec. 3, 1997, at 1773. As one professional stated, "It's too bad. We used to spend most of our time worrying about how to do a better job. Now we worry about doing a better job at a lower price." *Id.*
>
> Thousands of American physicians and nurses, outraged by the increasingly "corporate" nature of American medicine, recently staged a reenactment of the Boston Tea Party by symbolically dumping $1 million each minute into Boston Harbor to dramatize the amount of health care money that is being wasted to pay for HMO marketing, profits, and administrative salaries. *Id.* "The shift to profit-driven care is at a gallop. For nurses and physicians, the space for good work in a bad system rapidly narrows. For the public, who are mostly healthy and use little care, awareness of the degradation of medicine builds slowly; **it is mainly those who are expensively ill who encounter the dark side of market-driven health care.** . . . *Id.*

Herdrich v. Pegram, 154 F.3d 375 (citing: *For Our Patients, Not for Profits: A Call to Action*, at 1773, JAMA, (Dec. 3, 1997)) (emphasis added).

The second-guessing to which doctors are subject by managed care restrictions are frustrating the profession and hence the quality of care being provided:

> In fact, many observers note that **an increasing number of physicians are abandoning the profession because they are disenchanted with the notion of having "medically ignorant administrators" dictate that they limit patient care so as to pad the pockets of the officers of insurance companies and HMO organizations.** [Citing: Krauthammer, *Driving the Best Doctors Away; Physicians are Getting Hammered by Managed Care Micro-management and Malpractice Insurance Premiums*, Wash. Post, Jan. 9, 1998, at A21.] "More than money, this is what is driving these senior doctors crazy: some 24-year-old HMO functionary who knows as much about medicine as he does about cartography demanding to know why Mr. Jones, the diabetic in renal failure, has not been discharged from the hospital yet." *Id.*

Herdrich v. Pegram, 154 F.3d at 376. (emphasis added.)

The court also noted that insurance bureaucrats should not be dictating medical policy:

> We must remember that doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients. Trained physicians, and them alone, should be allowed to make care-related decisions (with, of course, input from the patient). **Medical**

> **care should not be subject to the whim of the new layer of insurance bureaucracy now dictating the most basic, as well as the important, medical policies and procedures from the boardroom**. If it is, "the cost cutting of managed health organizations and insurers may undermine what is, for now, the best medical care in the world." Beck, "*Drive-by Deliveries" Risky Health Game*, Hous. Chron., Oct. 28, 1995, at 36.

Herdrich v. Pegram, 154 F.3d at 377 (emphasis added).

VI. Altering Medical Records Borders on Criminal:

The extremes of the broad sweeping discretion given to HMOs under ERISA is no more evident than in this case. In Ashley Audet's case, what was done borders on, if not constitutes, a violation of Florida criminal law. It is a criminal offense to alter or falsify medical records:

> (1) Any person who fraudulently alters, defaces, or falsifies any medical record, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in § 775.082 or § 775.083.
>
> (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges.

§ 395.302 Fla. Stat. (1995).

If an offense rises to meet the statutory definition of a misdemeanor it must certainly be insurance bad faith. When such an offense approaches the level of criminal activity, ERISA should not work to protect the offender from civil accountability.

CONCLUSION

The opinions of the United States Court of Appeals for the Eleventh Circuit and the opinions of the other six Circuits remove a traditional remedy and tested deterrent for insurer bad faith that has become part of the fabric of the insurance law of nearly all the fifty states. Those laws serve to control insurers who over step the bounds of the policies they sell and commit bad faith. The public outcry and HMO abuse illustrated herein shows that managed care can not be allowed under ERISA to deny medically necessary treatment with impunity. The attention of this Court is needed to provide a meaningful disincentive to HMO and insurance company bad faith in ERISA-governed health care.

Respectfully submitted,

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